Submission for the Northern Territory Government's Public Accounts Committee

Inquiry into the Acacia Digital Patient Record System

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Background

I am writing this submission for the *Public Accounts Committee (PAC)* as the sister of Shaun Joyce, who died in August 2025, after working within the *Core Clinical System Renewal Program (CCSRP)* for almost 6 years. As of the date of this submission, there are multiple active investigations aiming to uncover evidence that can explain what happened to my brother. I am in a unique position in that I am a witness not only to what happened to Shaun, but also what went so wrong with the delivery of the digital system *Acacia*, as I was also employed in the program.

The governance failures in Acacia are inseparable from the same leadership culture that failed to manage psychosocial risk and comply with NT Government's *Work Health & Safety (WHS)* laws. The behaviours are identical: suppressing risks, discouraging escalation, altering or avoiding mandatory documentation, ignoring specialist advice, rewarding compliance with political narratives over factual accuracy, and retaliating against staff who raised concerns.

These cultural failures not only contributed to significant workplace harm but also produced a digital health system delivered without proper governance, safety processes, or technical accountability. The WHS failures and Acacia delivery failures are two outcomes of the same systemic breakdown.

The failures documented below expose the Territory to ongoing clinical risk, escalating financial liability, and an almost total loss of capability to continue the program safely. In addition to this I encourage you to request a copy of the Workforce Services Report in relation to my brother's death. I have spoken to dozens of people to provided evidence and believe that this will give you a solid insight into the culture.

Key Issues

1. Governance Failures in Ensuring Patient Safety

- The health and safety of patients must remain the highest priority in any clinical information system implementation. As part of the Acacia program, the Clinical Safety Officer (CSO) role was established to provide independent assurance that the solution being delivered supports safe patient care, that clinical risks are appropriately identified, assessed, and mitigated, and that safety concerns are transparently escalated through formal governance mechanisms.

As at the date of this submission, the program does not have a suitably qualified and experienced Clinical Safety Officer in place. Evidence indicates that members of the previous clinical safety team encountered repeated instances where non-clinical personnel, with no expertise in clinical safety or health informatics, intervened in and rewrote clinical safety artefacts. In doing so, identified clinical risks were down-played, re-characterised, or reframed to align with delivery or reputational objectives rather than patient safety imperatives. This interference fundamentally undermined the independence and integrity of the clinical safety function. The current backfill arrangement does not address this deficiency. While the individual holds AHPRA registration, they do not possess the requisite experience or qualifications in clinical safety governance or large-scale clinical information system implementation. This represents a significant governance failure, exposing NT Health to unmanaged clinical risk and compromising assurance that patient safety has been adequately protected throughout the Acacia delivery.

-The program uses a ticketing management system, Jira, to log and track issues. However, issues have not been managed effectively; there are currently 1,081 unresolved tickets relating to the delivery of Acacia 1.0 across all sites, with the oldest ticket dating March 2021, still sitting untouched. This reflects the long-term mismanagement of basic systems to deliver the product and explains the questionable quality of the implementation so far; as well as the feedback received from end users regarding the lack of training, guidance, and support.

2. Failures in Program Management and Delivery

-For several years CCSRP board meetings have been conducted with no delivery dates against the project. Evidence of this can be found in meeting minutes. This is highly unusual and shows a lack of transparency and accountability.

-The roadmap that was presented to ministers to secure funding for 2026/27 was not based on a detail schedule with proper resource allocation to support its viability. Like so many other delivery dates it was ‘best guess’. This means the program do not actually have a plan for how they will spend the funding envelop for 2026/27.

-Program Schedules have never aligned to any project management methodology. Routinely, dependencies were removed to fit a desired go live date. A recent example was the go live for ASH/TC where the program promised delivery prior to EOFY in order to reduce the reporting burden for NT Health. This was never possible based off required activities however the schedule was altered to make it appear possible. Ultimately the go live date was pushed and this resulted in unnecessary financial loss due to booked accommodation to support a June go live.

-There are currently >1000 open tickets associated with Acacia that require an action from the program. Many of these are enhancement requests. The program has not only failed to managed expectations about Acacia being an out of the box solution but actively encouraged stakeholder to identify enhancements. This is well documented with Acacia 1.0 Optimisation. From its inception the vendor was clear that they would not deliver or consider enhancements that didn’t have a clinical safety impact. The messaging to the business was contrary to this and much work was done by program staff and stakeholders to define enhancements. Evidence of this can be found in request for information (RFI) responses from the vendor and communications that were sent to NT Health Executives.

-Significant inefficiencies occurs in the management of Functional Group 2 (FG2) and Functional Group 3 (FG3). or several years, these teams were tasked with developing content intended for future Acacia (clinical documentation and medication management), investing substantial time and effort in preparation and design activities. However, around the beginning of 2024, these teams were prevented from progressing or deploying this work, with no clear direction, revised scope, or alternative workplan provided. As a result, for an extended period (approaching two years) teams remained largely under-utilised, with limited meaningful work to undertake. This represents a significant waste of public funds, workforce capability, and NT Health resources, and further demonstrates the absence of effective forward planning, sequencing of work, and alignment between program strategy and operational delivery. If these functional groups ever proceed the majority of this work will at best require revalidation but more likely need complete rework.

3. Long-Term Sustainability Risks

-Transition of Acacia management activities into business as usual (BAU) has failed. Acacia 1.0 expectation was that Acacia staff required to support the system would be absorbed into the existing Agency Business System's team of 4 staff, who also managed other digital systems. Acacia transition approach now appears to be to reduce program staff and to abandon the system without any handover or transition to BAU, or resources to do the work.

-Even after the deployment of Acacia 1.0 into all hospitals, Caresys remains in use for both read access & backend patient registration functionality & cannot be decommissioned. In order for this to occur the Enterprise Master Person Index (EMPI) needs to be working. EMPI is running on the server but not actually doing anything. This allows the program to report that this product has been implemented however the majority of the scope is outstanding. This was an issue raised by Shaun and he has emails outlining the need to find an 'owner' to complete along with a briefing paper.

4. Vendor Management and Release Risk

The project team ignored advice from the vendor and created a highly customised product which increases the likelihood of 'bugs' with each release. There are 6 releases per calendar year meaning they have created a system that will be challenging for NT Health to maintain on top of their current workload.

5. Leadership and Accountability Concerns

Program leadership lacking required technical and project capability:

- Program Directors did not follow standard project management or delivery methodologies, repeatedly failed to deliver core milestones, and presided over a deteriorating workplace culture.
- Multiple staff escalated concerns about a Program Director's behaviour in 2023, including claims of a toxic culture, yet commitments from senior executives to remove her were not acted on.
- Despite acknowledged performance and behavioural issues, they were retained as a contracted resource even after their demotion, reflecting a failure of accountability.

Inappropriate delegation of delivery leadership to unqualified personnel:

- Multiple staff progressed rapidly into senior delivery and product management roles despite lacking background in IT, health, or project delivery.
- They are now responsible for delivery of critical systems (functional groups 2-5) without the foundational expertise required, creating significant delivery and safety risk.

Senior management with insufficient capability to lead a complex health transformation program:

- Many Senior Leaders possessed no relevant health or digital health experience and demonstrated limited ability to lead or manage staff. Their approach was reactive and not impartial.
- Restructuring decisions appeared to reflect personal relationships rather than capability or organisational need, further degrading culture and delivery outcomes. Decisions around who was kept at the end of 2025 funding envelop were not documented or based on a skills matrix.

Conclusion

Acacia is no longer simply a troubled IT project, it is the outcome of a leadership culture that tolerated risk suppression, poor governance, and the mistreatment of staff. The consequences have been financial, clinical, organisational, and human. Unless these systemic failures are addressed, the Territory will continue to carry a program that is unsafe, unsustainable, and unaccountable. I urge the Committee to use its powers to obtain the full Workforce Services Investigation Report and related documents, and to take the steps required to protect both the public and the workforce. I am willing to provide further evidence at any time.